CHAPTER V

BILLING PROCEDURES

CHAPTER V
TABLE OF CONTENTS

CHAPTER V
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GENERAL INFORMATION

The requirements for the submission of independent laboratory claims and the use of the appropriate billing invoice depend upon the type of service being rendered and/or the billing transaction being completed.

Effective January 1, 1996, Medicaid claims for laboratory services must be submitted on the HCFA-1500 (12-90) form. Claims submitted on a form other than the HCFA-1500 (12-90), (such as the old DMAS-123 or DMAS-230) will be returned to you.

Photocopies or laser-printed copies of the HCFA-1500 (12-90) claim form will **NOT** be accepted. The requirement to submit claims on an original HCFA-1500 (12-90) claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form. These statements become part of the original billing invoice.

See billing instructions for completing the HCFA-1500 (12-90) for original claims as well as for adjustments and voids. Each block must be completed correctly and completely to receive payment for the services provided. Also, there is an important locator on the HCFA-1500 (12-90) claim form that must be completed correctly to ensure that your claims are processed timely. Locator 24B, Place of Service, must contain the value "81" (Independent Laboratory).

DMAS will not supply the HCFA-1500 (12-90) claim form. The HCFA-1500 (12-90) claim form may be obtained from an outside vendor. The HCFA-1500 (12-90) Health Insurance Claim Form is available from forms printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Printing Office
Superintendent of Documents
Washington, D.C. 20402
Telephone (202) 512-1800

The following two invoices are used when submitting claims for services where Medicare is the primary payer. See billing instructions in this chapter.

- Title XVIII (Medicare) Deductible and Coinsurance Invoice (DMAS-30)
- Title XVIII (Medicare) Deductible and Coinsurance Adjustment Invoice (DMAS-31)

Billed Amounts

Providers should bill the Virginia Medicaid Program their usual and customary charges for all services provided. The Medicaid claims processing system will calculate the reimbursement due according to the rules described in Chapter IV of this manual.

TIMELY FILING

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. If billing electronically and timely filing must be waived, submit the claim on paper with the appropriate attachments. Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished timely, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he or she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the letter from the local department of social services indicating the delayed claim information must be attached to the claim. On the HCFA-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Rejected or Denied Claims** - Rejected or denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the HCFA-1500 (12-90) invoice as explained under the “Instructions

for the Use of the HCFA-1500 (12-90) Billing Form" elsewhere in this chapter.

- **Attach** written documentation to verify the explanation. This documentation may be denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.

- Indicate Unusual Service by entering "22" in Locator 24D of the HCFA-1500 (12-90) claim form.

- Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

  Department of Medical Assistance Services
  Practitioner
  P. O. Box 27444
  Richmond, Virginia 23261-7444

  Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. Messenger or hand deliveries will not be accepted.

- **Exceptions** - The state Medicaid agency is required to adjudicate all claims within 12 months of receipt except in the following circumstances:

  - The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.

  - The claim is related to a Medicare claim which has been filed in a timely manner, and the Medicaid claim is filed within six months of the disposition of the Medicare claim.

  - This provision applies when Medicaid has suspended payment to the provider during an investigation and the investigation exonerates the provider.

  - The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those affected by it.

  The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for

services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

Preauthorized Services For Retroactive Eligibility

For services requiring preauthorization, all preauthorization criteria must be met in order for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorization will be performed by DMAS.

Electronic Submission of Invoices

Providers may submit claims by direct dial-up at no cost per claim, using toll-free telephone lines. Electronic Data Interchange (EDI) is a fast and effective way to submit your Medicaid claims. Claims will be processed faster and more accurately because electronic claims are entered into the claims processing system directly. Most personal, mini, or mainframe computers can be used for electronic billing.

Providers wishing to obtain information regarding submission of invoices via magnetic tape or diskette should contact the Electronic Media Claims Coordinator at:

Coordinator
Electronic Media Claims
FIRST HEALTH Services Corporation
P.O. Box 26228
Richmond, VA 23230

CLIA Certification

Any claims submitted by independent laboratories with dates of service on and after August 1, 1993, will be denied if no CLIA certificate and identification number are on file with DMAS. This requirement implements the federal Clinical Laboratory Improvement Amendment of 1988. To obtain a CLIA certificate and number or to obtain information about CLIA, call (410) 290-5850 or write

HCFA CLIA Program
P.O. Box 26689
Baltimore, Maryland 21207-0489

DMAS will deny laboratory claims of providers that bill for services outside of their CLIA

certificate type, reason 480 (provider not CLIA certified to perform procedure).

REPLENISHMENT OF BILLING MATERIALS

The Client Materials Management Unit of the Department of Medical Assistance Services is responsible for the distribution of all forms supplied by DMAS.

The Department of Medical Assistance Services Request for Forms/Brochures/Invoices/Envelopes (DMAS-161) must be used by providers to order forms or brochures. (See the "Exhibits" section at the end of this chapter for a sample of this form.) A six-month supply of forms should be ordered at least three (3) weeks prior to the anticipated need.

The Request for Forms/Brochures or Request for Billing Supplies must be submitted to:

Commonwealth Mailing Systems, Inc.
1700 Venable Street
Richmond, VA 23223

Direct any requests for information or questions concerning the ordering of forms to the address above or call: (804) 780-0076.

BILLING INSTRUCTIONS FOR THE HCFA-1500 (12-90) CLAIM FORM

Locator		Instructions
1	**Required**	**Enter an "X" in the Medicaid Box.**
1a	**Required**	**Insured's ID Number - Enter the 12-digit Virginia Medicaid identification number for the recipient receiving the service.**
2	**Required**	**Patient's Name - Enter the name of the recipient receiving the service as it appears on the identification card.**
3	Not Required	Patient's Birth Date
4	Not Required	Insured's Name
5	Not Required	Patient's Address
6	Not Required	Patient Relationship to Insured
7	Not Required	Insured's Address
8	Not Required	Patient Status
9	Not Required	Other Insured's Name
9a	Not Required	Other Insured's Policy or Group Number
9b	Not Required	Other Insured's Date of Birth and Sex
9c	Not Required	Employer's Name or School Name
9d	Not Required	Insurance Plan Name or Program Name
10	**Conditional**	**Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.) a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)**
10d	**Conditional**	**Enter "Attachment" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
11	Not Required	Insured's Policy Number or FECA Number
11a	Not Required	Insured's Date of Birth

11b	Not Required	Employer's Name or School Name
11c	Not Required	Insurance Plan Name or Program Name
11d	Not Required	Is There Another Health Benefit Plan?
12	Not Required	Patient's or Authorized Person's Signature
13	Not Required	Insured's or Authorized Person's Signature
14	Not Required	Date of Current Illness, Injury, or Pregnancy
15	Not Required	If Patient Has Had Same or Similar Illness
16	Not Required	Dates Patient Unable to Work in Current Occupation
17	**Conditional**	**Name of Referring Physician or Other Source**
17a	**Required**	**ID Number of Referring Physician - Enter the 7-digit Virginia Medicaid number of the referring physician.** **If the patient is in the MEDALLION or Client Medical Management Programs, the referring physician must be his or her primary care physician as indicated on his or her card.**
18	Not Required	Hospitalization Dates Related to Current Services
19	Not Required	
20	Not Required	Outside Lab?
21	**Required**	**Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD-9-CM diagnosis which describes the nature of the illness or injury for which the service was rendered.**
22	**Conditional**	**Medicaid Resubmission - Required for adjustments and voids. See additional instructions for submitting adjustments and voids on the HCFA-1500 (12-90).**
23	Not Required	Prior Authorization Number
24A	**Required**	**Dates of Service - Enter the From and Thru dates in a 2-digit format for the month, day, and year (e.g., 04/01/98). Dates must be within the same calendar month.**
24B	**Required**	**Place of Service - You MUST enter the 2-digit HCFA code, 81, for Independent Laboratories.**

24C Required **Type of Service - Enter the one-digit HCFA code, 5, for Diagnostic Laboratory.**

24D Required **Procedures, Services or Supplies**

CPT/HCPCS - Enter the 5-character CPT/HCPCS Code which describes the procedure rendered or the service provided.

Modifier - Enter the appropriate CPT/HCPCS Modifier(s) if applicable.

TC Technical Component
26 Professional Component
22 Unusual Service

SPECIAL NOTE: Although you may begin using the "TC" and "26" modifiers to reflect the level of service that you are providing, at this time we do not have the capability to recognize and modify payment based on their use. You will be notified when they have been activated in our system.

Modifier "22" must be used to pend a claim for manual review, such as a request for timely filing to be waived. Documentation must be attached to the claim. Enter "Attachment" in Locator 10D if documents are attached.

24E Required **Diagnosis Code - Enter the entry identifier of the ICD-9-CM diagnosis code listed in Locator 21 as the primary diagnosis.**

24F Required **Charges - Enter your total usual and customary charges for the procedure/services.**

24G Required **Days or Units - Enter the number of times the procedure, service, or item was provided during the service period.**

24H Conditional **EPSDT or Family Planning - Enter the appropriate indicator. Required only for EPSDT or Family Planning services.**

1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services

2 - Family Planning Service

24I Conditional **EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.**

24J Conditional **COB (Primary Carrier Information) - Enter the appropriate code.**

2 - No Other Coverage
3 - Billed and Paid
5.- Billed, No Coverage

24K	**Conditional**	**Reserved for Local Use - Enter the dollar amount received from the primary carrier if Block 24J is coded "3."**
25	Not Required	Federal Tax ID Number
26	**Optional**	**Patient's Account Number - Seventeen alpha-number characters are acceptable**.
27	Not Required	Accept Assignment
28	Not Required	Total Charge
29	Not Required	Amount Paid
30	Not Required	Balance Due
31	**Required**	**Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block**.
32	Not Required	Name and Address of Facility Where Services Were Rendered
33	**Required**	**Physician's, Supplier's Billing Name, Address, ZIP Code and Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your 7-digit Virginia Medicaid provider number in the PIN # Field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code.**

BILLING INSTRUCTIONS FOR COMPLETING THE HCFA-1500 CLAIM FORM (12-90) AS AN ADJUSTMENT INVOICE

The HCFA-1500 (12-90) Invoice for an adjustment is used to change information on a paid claim. Follow the instructions for the completion of the HCFA-1500 (12-90) except for the locator indicated below:

Locator 22 **Medicaid Resubmission**

Code - Enter the 3-digit code identifying the reason for the submission of the adjustment.

523 Primary Carrier has made additional payment
524 Primary Carrier has denied payment
525 Accommodation charge correction
526 Patient payment amount changed
527 Correcting service periods
528 Correcting procedure/service code
529 Correcting diagnosis code
530 Correcting charges
531 Correcting units/visits/studies/procedures
532 IC reconsideration of allowance, documented
533 Correcting admitting, referring, prescribing, provider identification number

Original Reference Number - Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each HCFA-1500 (12-90) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

BILLING INSTRUCTIONS FOR COMPLETING THE HCFA-1500 CLAIM FORM (12-90) AS A VOID INVOICE

The HCFA-1500 (12-90) Invoice is used to void a paid claim. Follow the instructions for the completion of the HCFA-1500 (12-90) except for the locator indicated below:

Locator 22 **Medicaid Resubmission**

Code - Enter the 3-digit code identifying the reason for the submission of the void.

542 **Original claim has multiple incorrect items**
544 **Wrong provider identification number**
545 **Wrong recipient eligibility number**
546 **Primary carrier has paid DMAS maximum allowance**
547 **Duplicate payment was made**
548 **Primary carrier has paid full charge**
551 **Recipient not my patient**
552 **Void is for miscellaneous reasons**
560 **Other insurance is available**

Original Reference Number - Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be adjusted on each HCFA-1500 (12-90) submitted as a Void Invoice. (Each line under Locator 24 is one claim.)

INSTRUCTIONS FOR BILLING MEDICARE COINSURANCE AND DEDUCTIBLE

Virginia Medicaid purchases Medicare Part B coverage for all Medicaid recipients eligible for Medicare benefits and makes payment to providers for Medicare coinsurance and deductible.

The Medicare Program Part B Carriers serving Virginia and the Virginia Medicaid Program have developed a system whereby these carriers will send to Virginia Medicaid the Medicare Explanation of Benefits (EOB) for identified Virginia recipients. This infor-mation will be used by the Program to pay Medicare coinsurance and deductible amounts as determined by the carrier. Do not bill Virginia Medicaid directly for services rendered to Medicaid recipients who are also covered by Medicare Program Part B carriers serving Virginia. However, the DMAS-31 adjustment form may be used when needed.

If the Medicare Part B carrier is one of these, bill Medicare directly on the appropriate invoice.

Upon receipt of the Medicare EOB, Virginia Medicaid will process payment automatically to participating providers when the recipient's Medicare number and the provider's Medicare vendor/provider number are in the Medicaid files. Those providers billing Medicare under more than one Medicare vendor/provider number must identify these numbers and names to the Medicaid Program to update its files. Medicare vendor/provider number additions or deletions must also be sent to the Program.

This automatic payment procedure includes Medicaid recipients with Railroad Retirement Medicare benefits.

If problems are encountered, the DMAS-30 invoice form should be completed, and a copy of the EOB attached and forwarded to:

Practitioner
Department of Medical Assistance Services
P. O. Box 27444
Richmond, Virginia 23261-7444

NOTE: Medicaid eligibility is reaffirmed each month for most recipients. Therefore, bills must be for services provided during each calendar month, e.g., 01-01-99 - 01-31-99.

Instructions for the Completion of the Virginia Medical Assistance Program Title XVIII (Medicare) Deductible and Coinsurance Invoice, DMAS-30 (See "Exhibits" at the end of this chapter for a sample of the form.)

Purpose To provide a method of billing Medicaid for Medicare deductible and coinsurance.

Explanation

Block 1 **Transmission Code** - This is a number assigned and preprinted by the Department of Medical Assistance Services.

Block 2 **Provider Identification Number** - Enter the seven-digit provider identification number assigned by Medicaid and the provider name and address.

Block 3 **Recipient's Name** - Enter the last name and the first name of the patient as they appear on the recipient's eligibility card.

Block 4 **Recipient Identification Number** - Record the 12-digit number taken from the recipient's eligibility card.

Block 5 **Patient Account Number** - If the provider uses a numbering system for patient identification, enter the patient's number in this block. This number will appear on the Remittance Voucher directly below the name. If no such system is used, leave this block blank

Block 6 **Recipient HIB Number** (Medicare) - Enter the recipient's Medicare number.

Block 7 **Primary Carrier Information** (Other Than Medicare) - Check the appropriate block. (Medicare is not the primary carrier in this situation.)

- **Code 2 - No Other Coverage** - If the Carrier Code on the recipient's card contains only the code 001 (Medicare) or contains no code, check Block 2.

- **Code 3 - Billed and Paid** - When a recipient has other coverage that makes payment which may only partly satisfy the Medicare deductible and coinsurance, check Block 3 and enter the payment received in Block 19. Attach a copy of the Medicare Explanation of Benefits. If the primary carrier pays as much as the combined totals of the deductible and coinsurance, do not bill Medicaid.

- **Code 5 - Billed and No Coverage** - If the recipient has other sources for payment of Medicare deductible and coinsurance which were billed and the service was not covered or the benefits had

been exhausted, check this block. Explain in the "Remarks" section.

Block 8 **Type Coverage (Medicare)** - Check Block B.

Block 9 **Diagnosis** - Leave blank.

Block 9A **Place of Treatment** - Enter the appropriate HCFA code:

00	Unassigned
11	Office
12	Home
10, 13-20	Unassigned
21	Inpatient Hospital
22	Outpatient Hospital
23	Emergency Room--hospital
24	Ambulatory surgical center
25	Birthing center
26	Military treatment center
27-29	Unassigned
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
30, 35-39	Unassigned
41	Ambulance--land
42	Ambulance, air or water
40, 43-49	Unassigned
51	Inpatient psychiatric facility
52	Psychiatric facility partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
50, 57-59	Unassigned
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
60, 63-64	Unassigned
65	End stage renal disease treatment facility
66-69	Unassigned
71	State or local public health clinic
72	Rural health clinic
70, 73-79	Unassigned
81	Independent laboratory
80, 82-89	Unassigned

99	Other unlisted facility
90-98	Unassigned

Block 10 **Accident Indicator** - Leave blank.

Block 11 **Type of Service** - Enter the appropriate HCFA code.

0	Whole Blood	H	Hospice
1	Medical Care	J	Diabetic shoes
2	Surgery	K	Hearing items and services
3	Consultation	L	ESRD supplies
4	Diagnostic Radiology	M	Monthly capitation payment for dialysis
5	Diagnostic Laboratory	N	Kidney donor
6	Therapeutic Radiology	P	Lump sum purchase of DME, prosthetics, orthotics
7	Anesthesia		
8	Assistant at surgery	Q	Vision items or services
9	Other medical items or services	R	Rental of DME
A	Used DME	S	Surgical dressings or other medical supplies
B	High risk screening mammography	T	Psychological therapy
C	Low risk screening mammography	U	Occupational therapy
D	Ambulance	V	Pneumococcal/flu vaccine
E	Enteral/parenteral nutrients/supplies	W	Physical therapy
F	Ambulatory surgical center	Y	Second opinion on elective surgery
G	Immunosuppressive drugs	Z	Third opinion on elective surgery

Block 11A **Procedure Code** - Enter the CPT/HCPCS procedure code for the primary procedure performed for the billing period. Use the appropriate HCFA procedure code modifier if applicable.

Block 11B **Visits/Units/Studies** - Enter the number of the procedures listed in Block 11A which were performed.

Block 12 **Date of Admission** - Leave blank.

Block 13 **Statement Covers Period** - Enter the beginning and ending dates of service taken from the Medicare Explanation of Benefits (EOB).

Block 14 **Charges to Medicare** - Enter the total charges submitted to Medicare.

Block 15 **Allowed by Medicare** - Enter the amount of the charges allowed by Medicare.

Block 16 **Paid by Medicare** - Enter the amount paid by Medicare (taken from the EOB). If there is no payment, put a zero.

Block 17 **Deductible** - Enter the amount of the deductible (taken from the Medicare EOB). If there is no deductible, put a zero.

Block 18 **Coinsurance** - Enter the amount of the coinsurance (taken from the Medicare EOB).

Block 19 **Paid by Carrier Other Than Medicare** - Enter the payment received from the primary carrier (other than Medicare). If Code 3 is checked in Block 7, an amount must be entered in this block. (Do not include Medicare payments.)

Block 20 **Patient Pay Amount, LTC Only** - Leave blank.

Signature Mechanics and Disposition

Signature of the provider or agent and the date signed are required. Information as explained above may either be typed or legibly handwritten. If an explanation regarding this claim is necessary, the "Remarks" section may be used. Separate and forward the original copy, along with a copy of the Medicare EOB attached, in the envelope supplied by the Program. Retain the provider's copy in the office files.

The correct address is:

Department of Medical Assistance Services
Independent Laboratory Services
P.O. Box 27446
Richmond, VA 23261-7446

Instructions for the Completion of the Department of Medical Assistance Services Medicare Deductible and Coinsurance (Title XVIII) Adjustment Invoice, DMAS-31 (Revised 6/96)

Purpose To provide a means of making corrections or changes that have been approved for payment. This form cannot be used for follow-up of denied, rejected, or pended claims. (See the "Exhibits" section at the end of this chapter for a sample of this form.)

Explanation To void the original payment, the information on the adjustment invoice must be identical to the original invoice. To correct the original payment, the adjustment invoice must appear exactly as the original should have.

Block 1 **Adjustment/Void** - Check the appropriate block.

Block 2 **Provider Identification Number** - If not preprinted, enter the 7-digit number assigned by DMAS. The provider name and address should also be entered if not preprinted.

This number is preprinted on the invoice with the name and address of the provider and the transmission code. Since the name of the provider and the provider identification number are required before an invoice can be processed, the invoice should never be submitted without these two items of information.

Block 2A **Reference Number** - Enter the reference number taken from the Title XVIII Deductible and Coinsurance Remittance Voucher for the line of payment needing adjustment. The reference number (nine digits) follows the recipient's eligibility number on the remittance voucher. The adjustment/void cannot be made without this number since it identifies the original invoice.

Block 2B **Reason** - Leave blank.

Block 2C **Input Code** - Leave blank.

Blocks 3-20 Refer to the instructions for DMAS-30 for the completion of these blocks.

Remarks This section of the invoice should be used to give a brief explanation of the change needed.

Signature Signature of the provider or agent and the date signed are required.

Mechanics and Disposition **The form may either be typed or legibly handwritten.** Separate and forward the intermediary copy in the pre-addressed envelope supplied by the Program. Retain the provider's copy in the office files.

The correct address for the Coinsurance and Deductible Invoice is:

Department of Medical Assistance Services
Practitioner
P. O. Box 27444
Richmond, Virginia 23261-7444

REMITTANCE VOUCHER (PAYMENT VOUCHER)

DMAS sends a remittance voucher with each payment. This voucher is a listing of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five years.

The check is the last item in the envelope. The remittance voucher includes an address sheet which has been added for security purposes. The address sheet contains the provider's name and address. The remittance voucher contains a space for special messages from the Department.

Participating providers are encouraged to monitor the remittance vouchers for special messages that will expedite notification on matters of concern. This mechanism may be used to alert providers on matters that may relate to:

- Pending implementation of policies and procedures
- Sharing clarification on a concern expressed by a provider

CLAIM INQUIRIES

Inquiries concerning covered benefits, specific billing procedures, or remittances should be directed to:

Provider Inquiry Unit
Division of Client Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Telephone Numbers

786-6273	Richmond Area
1-800-552-8627	All Other Areas

INVOICE PROCESSING

The Medicaid invoice processing system uses a sophisticated electronic system to process

Medicaid claims. Once a claim has been received, microfilmed, assigned a cross-reference number, and entered into the system, it is placed in one of the following categories:

- Rejects - unprocessable for some reason and returned to the provider. These claims should be resubmitted on a new invoice with corrected data.

- Remittance Voucher

  - **Approved** - Payment is approved or placed in a pended status for manual adjudication (the provider must not resubmit).
  - **Denied** - Payment cannot be approved because of the reason stated on the remittance voucher.

- No Response - **If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form.**

The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

EXHIBITS

TABLE OF CONTENTS

Department of Medical Assistance Services Request for Forms/Brochures/Invoices/Envelopes

Company Name _____ Contact Person _____ Date _____ Telephone # (_____) _____

Provider DMAS ID Number _____ Mail To Address _____

Quantity	DMAS Form #	Form Name	Quantity	DMAS Form #	Form Name
____	4	Savings for Medicare Beneficiaries	____	119	Social History Form
____	4-A	EPSDT Poster	____	121	Certificate of Patient Status@50pd
____	5	About Your Medicaid Appeal	____	121A	Certificate of Patient Rehab.Services@50pd
____	6B	Answers Your? HIV Premium Assistance Prog.	____	122	Patient Information R 12/98@50pd
____	16	Maternity Risk Screen	____	125	Rehab.Treatment Authorization@25pd
____	17	Infant Risk Screen	____	161	Request for Forms/Brochures/Invoices/Envelopes
____	20	Consent Form for Release of Information	____	173	Drug Claim Ledger Invoice
____	30	Title XVIII Invoice	____	175	Pharmacist Intervention Report@25pd
____	31	Title XVIII Adjustment Invoice	____	177	Patient Counseling Log@25pd
____	50	Maternal Care Coordinator Record@25pd	____	201	Notification Medicaid Transportation Denial
____	51	Infant Care Coordinator Record@25pd	____	213	Newborn Eligibility Report
____	52	Care Coordination Service Plan@25pd	____	216	Medicaid/HMO Overnight Last Day Month
____	53	Pregnancy Outcome Report@25pd	____	228	Drug Claim Adjustment Invoice
____	54	Infant Outcome Report@25pd	____	300	Respite Care Needs Assessment & Plan of Care
____	55	Care Coordination Letter Agreement@25pd	____	301	Adult Day Health Interdisciplinary Plan of Care
____	70	Practitioner Referral Form	____	302	Adult Day Health Care Daily Log
____	80	Patient Intensity Rating System @50pd	____	351	Pre-Authorization Request@50pd
____	89	Personal Care Rec. Admissions Envelope	____	352	Certification of Medical Necessity
____	90	Personal Care Aide Record@25pd	____	353	EPSDT Medical History Form
____	95	UAI Assessment Process	____	353A	EPSDT Screening Documentation Form
____	95A	UAI Assessment Process (part A only)	____	354	IV Therapy Implementation Form
____	95B	UAI Assessment Process (part B only)	____	412	Request Psych.ExtensionTreatment@25pd
____	95-1	MIMR Supplemental Assessment Process #1	____	420	Request for Hospice Benefits
____	95-2	MIMR Supplemental Assessment Process #2	____	420A	Request For Hospice Benefits(Continued)
____	96	Nursing Home PreAdmission Screening Plan	____	421	Hospice Benefits Revocation/Change
____	97	Plan of Care-Personal Care Services@25pd	____	430	ISAR MR Waiver Crisis Stabilization
____	97A	Provider Agency Plan of Care@25pd	____	431	ISP Therapeutic Consultation
____	97B	Consumer-Directed Plan of Care	____	432	ISP MRCMS CSP Selected Goal
____	99	Comm. Based Care Recipient Assessment Rpt.	____	433	ISP MR Case Mgmt 90 Day Assessment
____	99B	Consumer-Directed Assessment Report	____	434	ISP 60 Day Assessment
____	100	Request Supervision Personal Care Plan@25pd	____	435	ISP Respite Care
____	101	MH/MR Service Needs Summary@25pd	____	436	ISP Personal Assistance Services
____	102	DMAS Private Duty Nursing Plan of Care	____	437	MR Waiver Enrollment Request
____	103	Monthly Nursing Status Report	____	438	MR Waiver Plan of Care Summary
____	113A	HIV Services Pre-Screening Assessment	____	439	ISAR MR Waiver 60-Day Assessment
____	113B	HIV Waiver Pre-Screening Plan of Care	____	440	ISAR MR Waiver Residential Support
____	114	AIDS Waiver Authorization Form	____	441	ISAR MR Waiver Supported Employment
____	115	Nutritional Information Form	____	442	ISAR MR Waiver Day Support

Quantity	DMAS Form #	Form Name
____	443	ISAR MR Waiver Personal Assistance
____	444	ISAR MR Waiver Respite
____	445	ISAR MRWaiverTherapeuticConsultation
____	446	ISAR MR Waiver Environmental Mod.
____	447	ISAR MR Waiver Assistance Technology
____	448	ISAR MR Waiver Nursing Services
____	449	Determining Periodic Support Hours
____	450	ISP-Crisis Stabilization
____	451	Individual Service Plan
____	452	ISP MR Case Management
____	453	DD Waiver Enrollment Request
____	456	DD Waiver Consumer Service Plan
____	457	DD Waiver Supporting Documentation
____	458	Level of Functioning Survey
____	459	Documentation of Consumer Choice
____	500	HIPP Application
____	501	HIPP Medical History Questionnaire
____	502	HIPP Employer Verification
____	503	HIPP Policy Holder Information
____	701	Dental Invoice
____	702	Dental Adjustment Invoice
____	704	Dental Pre-Authorization Request
____	750	Fraud Claim Request
____	751	Notice:Recipient Fraud/Non-Fraud Overissuance
____	999	Third Party Liability Information Report
____	1000	Third Party Reporting Form
____	3004	Sterilization Consent Form
____	3005	Acknowledgement of Receipt of Hysterectomy Information
____	3006	Abortion Certification R 3/99
____	4000	Prosthetic Device Pre-Authorization Form
____	4001	Physician Certification of Need

Quantity	DMAS Form #	Brochure Name
____	1	Hospital Brochure
____	1	EPSDT Booklet in English
____	1A	EPSDT Poster
____	1S	EPSDT Booklet in Spanish
____	2	Virginia Medicaid Handbook
____	60	BabyCare Booklet (English)
____	61	BabyCare Booklet (Spanish)
____	67	A Guide for Virginians with Disabilities
____	250	Intro/State-Funded LongTermCare System
____	252	AIDS Waiver Services
____	253	Consumer-Directed PersonalAttendant Ser.
____	254	Elderly and Disabled Waiver
____	255	Mental Retardation Waiver
____	256	Nursing Facility Services
____	257	All-Inclusive Care for Elderly (PACE)
____	258	Technology Assisted Waiver
____	259	Technology Assisted Waiver/EPSDT Nursing Services Provider

Quantity	DMAS Form #	Envelope Name
____	24	SLH Mailing
____	89	Personal Care Recipient Admissions
____	660	Hospital Inpatient/Outpatient
____	663	Practitioner Envelope
____	664	Drug Claim
____	703	Dental Claim

You May Send, Call or Fax Your Order to:

ADDRESS: DMAS Order Desk Commonwealth Mailing Systems, Inc. 1700 Venable Street Richmond, VA. 23223	**Order Desk Telephone # : 804-780-0076** **Order Desk Fax # : 804-780-0198**

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) CHAMPUS (Sponsor's SSN) CHAMPVA (VA File #) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. AUTO ACCIDENT? YES NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes,* return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 3.

2. 4.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A DATE(S) OF SERVICE From MM DD YY To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1										
2										
3										
4										
5										
6										

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

PIN# GRP#

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88)

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCP-1500 FORM RRB-1500

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

091

1 TRANSMISSION CODE | 2 PROVIDER I.D. NO.(7)

0

3 RECIPIENT'S LAST NAME	FIRST NAME	4 RECIPIENT I.D. NUMBER (12)	5 PATIENT ACCOUNT NUMBER	6 RECIPIENT'S HIB NUMBER (MEDICARE)

7 PRIMARY CARRIER INFORMATION OTHER THAN (MEDICARE)	8 TYPE COVERAGE (MEDICARE)	9 DIAGNOSIS	9A PLACE OF TREAT (2)	10 ACCIDENT/EMERG. INDICATOR	11 TYPE SERV (1-2)	11A PROCEDURE CODE (5)	11B	12 DATE OF ADMISSION	13 STATEMENT COVERS PERIOD FROM / THRU
☐ 2 NO OTHER COVERAGE ☐ 3 BILLED AND PAID ☐ 5 BILLED NO COVERAGE	☐ A ☐ B			☐ ACC ☐ EMER ☐ OTHER				MO (2) DAY (2) YEAR (2)	MO (2) DAY (2) YEAR (2) / MO (2) DAY (2) YEAR (2)

14 CHARGES TO MEDICARE	15 ALLOWED BY MEDICARE	16 PAID BY MEDICARE	17 DEDUCTIBLE	18 COINSURANCE	19 PAY BY CARRIER OTHER THAN MEDICARE	20 PATIENT PAY AMOUNT LTC ONLY

1

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14 CHARGES TO MEDICARE	15 ALLOWED BY MEDICARE	16 PAID BY MEDICARE	17 DEDUCTIBLE	18 COINSURANCE	19 PAY BY CARRIER OTHER THAN MEDICARE	20 PATIENT PAY AMOUNT LTC ONLY

REMARKS: IDENTIFY LINE ITEM TO WHICH REMARKS REFER

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

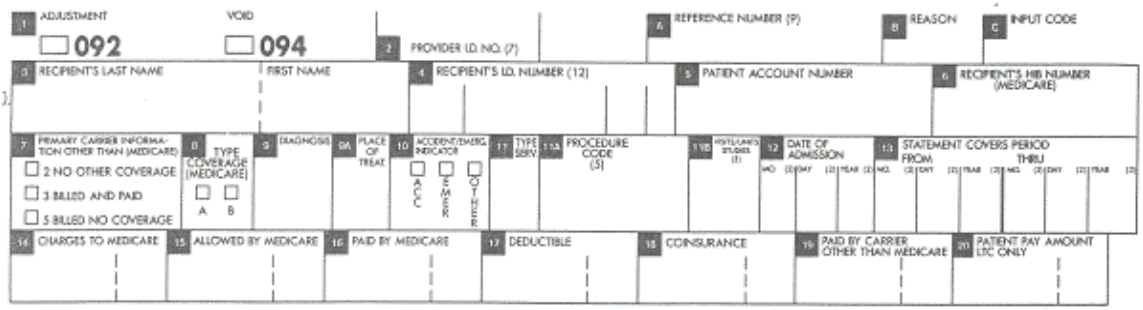
ORIGINAL COPY

DMAS - 30 R 4/96

TITLE XVIII (MEDICARE) DEDUCTIBLE AND COINSURANCE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES



_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER OF THE PAID CLAIM AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

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SIGNATURE DATE

ORIGINAL COPY

DMAS 31 R 6/96